1. Room and board;

2. Administration of medication and treatment and all nursing services;

3. Development, management, and evaluation of the written patient care plan based on physician orders that necessitate the involvement of skilled technical or professional personnel to meet the recipient's care needs, promote recovery, and ensure the recipient's health and safety;

4. Observation and assessment of the recipient's unstable condition that requires the skills and knowledge of skilled technical or professional personnel to identify and evaluate the recipient's need for possible medical intervention, modification of treatment, or both, to stabilize the recipient's condition;

5. Health education services, such as gait training and training in the administration of medications, provided by skilled technical or professional personnel to teach the recipient self-care;

6. Provision of therapeutic diet and dietary supplement as ordered by the attending physician;

7. Laundry services, including items of recipient's washable personal clothing;

8. Basic nursing and treatment supplies, such as soap, skin lotion, alcohol, powder, applicators, tongue depressors, cotton balls, gauze, adhesive tape, Band-Aids, incontinent pads, V-pads, thermometers, blood pressure apparatus, plastic or rubber sheets, enema equipment, and douche equipment;

9. Non-customized durable medical equipment and supplies that are used by individual recipients, but which are reusable. Examples include items such as ice bags, hot water bottles, urinals, bedpans, commodes, canes, crutches, walkers, wheelchairs, and side-rail and traction equipment;

10. Activities of the patient's choice (including religious activities) that are designed to provide normal pursuits for physical and psychosocial well being;

11. Social services provided by qualified personnel;

12. Maintenance Therapy; provided, however, that only the costs that would have been incurred if nursing staff had provided the Maintenance Therapy will be included in calculating the Basic PPS Rates;

13. Provision of and payment for, through contractual agreements with appropriate skilled technical or professional personnel, other medical and remedial services ordered by the attending physician which are not regularly provided by the Provider. The contractual agreement shall stipulate the responsibilities, functions, objectives, service fee, and other terms agreed to by the Provider and the person or entity that contracts to provide the service; and

14. Recurring, reasonable and incremental costs incurred to comply with OBRA 87.

B. The costs of providing the following items and services shall be specifically excluded from reimbursement under this Plan and shall be billed separately to the Department by the Providers:

1. Physician services, except those of the medical director and quality assurance and/or utilization review committees;

2. Drugs that are provided to Residents in accordance with Title XIX policy;

3. Laboratory, X-ray, and EKG;

4. Ambulance and any other transportation for medical reasons that is not provided by the Provider and not included in the costs used to calculate the Basic PPS Rates;

5. Dental;

6. Optical;

7. Audiology;

8. Podiatry;

9. Physical therapy, excluding Maintenance Therapy;

10. Occupational therapy, excluding Maintenance Therapy;

11. Speech, hearing and respiratory therapies; and

12. Customized durable medical equipment and such other equipment or items that are designed to meet special needs of a Resident and are authorized by the Department.

13. Charges for ancillary services are not included in calculating the Basic PPS Rates and shall be paid as follows:

a) Providers that have the capability shall bill the Department separately for ancillary services.

b) The Department shall make an Ancillaries Payment to Providers that it designates as incapable of billing for ancillary services on an itemized basis.

c) In order to receive an Ancillaries Payment, the Provider must make assurances satisfactory to the Department that it is committed to acquiring the ability to bill on an itemized basis for ancillaries, and is pursuing that goal with all deliberate speed.

d) As part of the FY 98 Rebasing, the Department shall identify ancillary services for which a Provider lacks the ability to bill separately and calculate a per diem amount as an Ancillaries Payment.

e) No Provider that receives an Ancillaries Payment shall otherwise bill the Department separately on behalf of a Title XIX Resident for any type of ancillary service that is included in calculating its Ancillaries

Payment. A Provider that receives an Ancillaries Payment must also implement procedures and assure the Department that no other person or entity will bill separately for any type of ancillary service that is included in calculating the Ancillaries Payment.

f) The Provider shall provide to the Department upon request the progress that it is making in its efforts to acquire the ability to bill separately for ancillary services. If and when the Provider acquires that ability, then it shall promptly notify the Department in writing.

g) Once the Department determines that a Provider is capable of billing for some or all ancillary services on an itemized basis, then it shall provide advance written notice to that Provider of a date upon which it will either cease making or reduce the Ancillaries Payment. If the Provider acquires the capability of billing for some (but not all) ancillary services that were included in calculating its Ancillaries Payment, then the Department shall reduce the Ancillaries Payment accordingly.

h) The Department shall make available all necessary data to ensure the appropriate accounting for ancillary services.

C. The personal funds of Medicaid recipients may not be charged any costs for routine personal hygiene items and services provided by the Provider.

IV. CLASSIFICATION OF LONG-TERM CARE PROVIDERS INTO PEER GROUPS

For the purpose of establishing the Basic PPS Rates, Providers and costs shall be grouped into the following five mutually exclusive classifications or peer groups:

A. The costs of delivering care to Acuity Level A Patients in freestanding Nursing Facilities;

B. The costs of delivering care to Acuity Level C Patients in freestanding Nursing Facilities;

C. The costs of delivering care to Acuity Level A Patients in hospital-based Nursing Facilities;

D. The costs of delivering care to Acuity Level C Patients in hospital-based Nursing Facilities;

E. The costs of delivering care to Acuity Level B Patients in ICF/MRs.

V. BASIC PPS RATE CALCULATION METHODOLOGY

Unless otherwise noted, the Basic PPS Rates shall be calculated using the methodology set forth in this Section V.

A. Data Sources for Rate Calculation

1. The Department shall select the Base Year. The Base Year selected shall be the most recent state fiscal year for which cost reports for the significant majority of Providers are available. The Department shall select the most recent year for which cost reports for the significant majority of Providers are available but are not finally settled (i.e., the "as filed" cost reports). The Department shall identify and apply an Audit Adjustment Factor to the "as filed" cost reports.

2. Cost and census day data to be used in the development of the Basic PPS Rates shall be abstracted from the uniform cost report that is submitted to the Medicaid agency by each Provider. If the Department determines that additional data is required, then additional cost and census data shall be solicited from the Provider.

B. Calculation of Component Per Diem Costs by Reference to Each Provider's Base Year Cost Report

1. Cost data shall be abstracted from the Base Year Cost Report and categorized into the following three components:

a) Direct nursing costs shall include all allowable costs involved in the direct care of the patient. Examples of such costs include the following:

(1) salaries for nurses' aides, registered nurses, and licensed practical nurses not involved in administration;

(2) the portion of employee fringe benefits that are properly allocated to those salaries;

(3) physician-ordered Maintenance Therapy, which is not billed directly to the Department. The cost of Maintenance Therapy services provided by persons other than nursing staff shall be limited to an amount equivalent to the cost if performed by nursing staff or a physical therapy aide; and

(4) costs of nursing supplies and medical supplies not separately billable to patients.

b) Capital costs shall include all allowable capital related operating costs under Medicare reasonable cost principles of reimbursement (as defined in 42 C.F.R. chapter 413) of the long-term care facility or distinct part unit. Examples of such costs include the following:

(1) rent;

(2) interest;

(3) depreciation;

(4) equipment or lease rental;

(5) property taxes; and

(6) insurance relating to capital assets.

c) G&A costs shall include all additional allowable costs incurred in providing care to long-term care patients. Examples of such costs shall include the following:

(1) dietary;

(2) housekeeping;

(3) laundry and linen;

(4) operation of plant;

(5) medical records;

(6) the costs of insuring against or paying for malpractice, including insurance premiums, attorneys' fees and settlements of claims; and

(7) the costs of fringe benefits properly allocated to employees involved in general and administrative duties.

2. The costs identified in Section V.B.1 shall be adjusted as follows:

a) Costs allocated to line items on the Base Year Cost Report other than those components listed in Section V.B.1, or to inappropriate line items, shall be appropriately reclassified to the three components. Reclassification shall be performed by the Department or its fiscal agent. If Maintenance Therapy is identified as a separate line item on the Provider's cost report, then the Department shall include those costs in calculating the PPS Rates. The Department shall not, however, allow reclassifications of Maintenance Therapy costs from the physical or occupational therapy ancillary cost center to routine costs.

b) Costs of services specifically excluded from the Basic PPS Rate under Part III.B shall be deleted from the costs identified in Section V.B.1 for the purpose of

the Basic PPS Rate calculation. This process shall involve identifying line items from the Base Year Cost Report or other financial records of the Provider pertaining to the excluded services and subtracting these costs from the appropriate component. If a Provider's Base Year Cost Report does not identify the costs of excluded services, then the Department shall so advise the Provider and request additional financial records. If the Provider does not respond with appropriate information, then the Department may delete from the Provider's costs an amount reasonably estimated to represent the costs of such excluded services.

c) Cost reports for facilities which first began operations after the beginning of the Base Year are not included in calculating the statewide weighted average per diem costs or used to calculate the Provider's Basic PPS Rate.

d) Costs attributable to new beds that are placed in service after the beginning of the Base Year are also not included in calculating the statewide weighted average per diem costs or used to calculate the portion of the Provider's Basic PPS Rate that relates to the new beds.

e) Where an existing facility has partial year cost reports from more than one owner or operator, the Department may either select one of the partial year cost reports or combine the cost reports from the former and current owners/operators. In either case, the cost reports shall be adjusted to approximate the costs that would have been incurred for a twelve-month period.

f) Gross excise taxes paid on receipts, NF taxes, and any return on equity received by a for-profit Provider shall be deleted from the costs used to calculate the Basic PPS Rate and shall be reimbursed separately.

g) If a Provider received a rate increase pursuant to a rate reconsideration request in the Base Year, and that increase is for a non-recurring cost, then the Department may delete from the Base Year costs that are included in calculating the Basic PPS Rates an amount equal to the costs that were used to calculate the rate increase.

h) If a Provider received supplemental payments from the State (with no federal matching funds) for special services in the Base Year, then the Department shall adjust the Provider's Base Year costs to remove the differential costs of those special services in calculating the Provider's Basic PPS Rates.

i) The resulting component costs and return on equity shall be standardized to remove the effects of varying fiscal year ends. Costs are inflated from the end of each provider's fiscal year to a common point in time. Therefore, facilities with fiscal years that end earlier receive a higher rate (more months) of inflation.

j) To recognize annual inflationary cost increases, these standardized component costs shall be inflated as described in Section VII.A.

k) For Nursing Facility Providers, the portions of a Provider's standardized and inflated costs (except for the costs of Maintenance Therapy services included in direct nursing costs and the costs of complying with OBRA 87) that are in excess of federal routine operating cost limits (excluding the add-on to those limits for OBRA 87 Costs) for long-term care facilities shall be deleted from the costs used to calculate the Basic PPS Rates. The Department shall apply the federal routine operating cost limits for urban Honolulu facilities to all Nursing Facilities.

l) Costs that are not otherwise specifically addressed in this Plan shall be included in base year costs if they comply with HCFA Publication No. 15 standards.

m) Legal expenses for the prosecution of claims in federal or state court against the State of Hawaii or the Department incurred after September 30, 1988, shall not be included as allowable costs in determining the PPS per diem rates.

3. A Provider-specific per diem component cost shall be calculated by dividing the costs associated with each component identified in Section V.B.1, as adjusted in Section V.B.2, by the number of long-term care Provider census days for each acuity level reported on the cost report and segregated in accordance with the classifications in Part IV.

4. For Providers with both Acuity Levels A and C Residents in the Base Year, per diem component rates shall be established as follows:

a) Costs as reported on the Base Year Cost Report shall be used for the computation of the Level A and Level C per diem component rates for Providers which report costs for Acuity Levels A and C Patients separately.

b) If a Provider reports combined costs for Acuity Levels A and C and does not segregate its direct nursing costs based upon a case mix method or study, then the Department shall allocate the Provider's direct nursing costs based upon the Acuity Ratio.

c) Costs for the general and administrative component shall be allocated equally on a per diem basis between Acuity Levels A and C, or at the Provider's option, allocated by the Provider using the same case-mix index developed for nursing costs.

d) Capital costs shall be allocated equally between Acuity Levels A and C on a per diem basis.

e) In no case shall a Provider's Acuity Level A per diem costs exceed its Acuity Level C per diem costs.